

Wraparound Summary Plan Description (SPD)

of Employee Welfare Benefits of

Roger Williams University

This SPD applies to:

Roger Williams University Welfare Plan – Plan # 501

THIS WILL ALSO SERVE AS THE **PLAN DOCUMENT**
FOR THE BENEFITS OUTLINED HEREIN EXCEPT AS OTHERWISE NOTED

NOTE: The information contained herein is current as of January 1, 2014

INTRODUCTION

This Wraparound Summary Plan Description (SPD) is intended to provide you with an overview of the benefits (herein "component benefits") that are available under the employee welfare Plan offered by **Roger Williams University**. This SPD is not a contract and does not guarantee any benefits. The actual terms and conditions of the Plan's component benefits are contained in the various insurance policies, booklets, and plan documents etc. (herein "Benefit Documents") and are incorporated by reference. A listing of those documents is shown in the **PLAN BENEFITS** section.

This SPD is also intended to provide you with certain information as required by the Employee Retirement Income Security Act of 1974 ("ERISA") as well as other important information. In the event of any conflict between the information contained in this SPD and any Benefit Document, the terms of the Benefit Document will control.

If you have any questions that are not answered by this Wrap Document, please contact

**Department of Human Resources
Roger Williams University
One Old Ferry Road
Bristol, RI 02809
401-254-3028**

IMPORTANT: The Employee Retirement Income Security Act (ERISA) is federal law. In general, it is not the intent of the SPD to provide benefit language or information that is mandated by any state insurance code. State-mandated benefits and information are as included in the Benefit Documents issued by the respective insurance carriers.

With regard to COBRA Continuation Coverage rights and those component benefits where COBRA applies, please examine your options carefully before declining COBRA coverage. Where COBRA applies, the COBRA provisions in the respective Benefit Document will supersede any COBRA provisions in this Wrap Plan/SPD. You should also be aware that companies selling individual health insurance typically require a review of your medical history that could result in higher premiums or you could be denied coverage entirely.

Also, be aware that voluntary termination of existing COBRA Continuation Coverage does not trigger a mid-year "special enrollment right" under another group health plan.

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Additional Benefit Information - Who to Contact

A Plan participant or beneficiary can obtain additional information, free of charge, about Plan coverage of a specific drug, treatment, procedure, preventive service, etc. from his/her benefit provider (see "Provider" in the **PLAN BENEFITS** section). The name, address and phone number of the provider is as shown in the applicable benefit information section.

Childrens' Health Insurance Program Reauthorization Act (CHIPRA) or Medicaid

Effective April 1, 2009, employees and dependents who are eligible but not enrolled for the employer's group health plan, may enroll for coverage thereunder in the following instances:

Loss of Medicaid or CHIP Eligibility: If the employee's or dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, the employee may request coverage under the employer's group health plan within sixty (60) days after Medicaid or CHIP coverage terminates.

Eligibility for State Premium Assistance: Where a State has chosen to offer premium assistance subsidies for qualified employer-sponsored benefits and if the employee or dependent becomes eligible for such subsidy under Medicaid or CHIP, then the employee may request coverage under the employer's group health plan within sixty (60) days after eligibility for the subsidy is determined.

The above represent new "Special Enrollment Rights."

Also, if an employee's child(ren) become eligible for CHIP (known as "Healthy Families" in California), the employee has the ability to drop the child(ren) from the group health coverage.

Additional information is available here: <http://www.rwu.edu/sites/default/files/downloads/hr/chip.pdf>

COBRA Notice Requirements for Plan Participants

A Plan participant must provide the following Notices as they relate to COBRA Continuation Coverage:

Notice of Divorce or Separation: Notice of a divorce or legal separation of a covered employee from his or her spouse.

Notice of Child's Loss of Dependent Status: Notice of a child's loss of dependent status (e.g., a dependent child reaching the maximum age limit).

Notice of a Second Qualifying Event: Notice of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.

Notice Regarding Disability: Notice that: (a) a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled during the first 60 days of continuation coverage, or (b) a Qualified Beneficiary as described in "(a)" has subsequently been determined by the Social Security Administration to no longer be disabled.

Notice Regarding Address Changes: It is important that the Plan Administrator be kept informed of the current addresses of all Plan participants or beneficiaries who are or may become Qualified Beneficiaries.

Notification must be made in accordance with the following procedures. However, these procedures are current as of the date this document was prepared and a Qualified Beneficiary should make certain that procedure changes have not occurred before relying on this information. The most current information is included in the Employer's COBRA Initial General Notice provided to new hires.

Any individual who is either the covered employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered employee or Qualified Beneficiary may provide the Notice. Notice by one individual shall satisfy any responsibility to provide Notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Form, Content & Delivery - Notification of the Qualifying Event must be provided to the Employer/Plan Administrator on a "Notice of Qualifying Event form." The form can be obtained from the following office and should be requested immediately after a qualifying event has occurred:

OTHER IMPORTANT NOTICES

**Department of Human Resources
Roger Williams University
One Old Ferry Road
Bristol, RI 02809
401-254-3028**

Time Requirements: In the case of a divorce, legal separation or a child losing dependent status, Notice must be delivered within 60 days from the later of: (1) the date of the Qualifying Event, (2) the date health plan coverage is lost due to the event, or (3) the date the Qualified Beneficiary is notified of the obligation to provide Notice through the Summary Plan Description or the Plan Sponsor's General COBRA Notice. If Notice is not received within the 60-day period, **COBRA Continuation Coverage** will not be available, except in the case of a loss of coverage due to foreign competition where a second COBRA election period may be available – see "Effect of the Trade Act" in the **COBRA Continuation Coverage** section of the Plan's Summary Plan Description or Plan Document.

If an employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, Notice must be delivered within 60 days from the later of: (1) the date of the determination, (2) the date of the Qualifying event, (3) the date coverage is lost as a result of the Qualifying Event, or (4) the date the covered employee or Qualified Beneficiary is advised of the Notice obligation through the SPD or the Plan Sponsor's General COBRA Notice. Notice must be provided within the 18-month COBRA coverage period. Any such Qualified Beneficiary must also provide Notice within 30 days of the date he is subsequently determined by the Social Security Administration to no longer be disabled.

Medical Loss Ratio ("MLR") Rebates

The "Patient Protection and Affordable Care Act" requires health insurers to spend a minimum percentage of premium dollars on health care services and activities to improve health care quality. This is generally known as the "Medical Loss Ratio" or (MLR). The percentage is 85% for issuers in the large group market and 80% for issuers in the small and individual group markets. Issuers that do not meet the applicable MLR standard must provide rebates to consumers.

Rebates must be paid by August 1 following the end of the MLR reporting year.

Method for Allocating the Rebate: The amount of the rebate is to be split between the employer and its' participants. The portion to be used for the benefit of the employees is generally determined by reference to the employees' share of the premiums paid during the previous Plan Year. For example, if employees must pay 25% of the total premiums charged to the employer, then 25% of the premium must be applied for the benefit of the employees.

Application of the Rebate: The final decision to be made by the employer is how to apply the employees' share of the rebate. As a practical matter, an employer has two options:

- 1) Pay the rebate to members of the eligible class in cash (as additional taxable wages); or
- 2) Reduce the amount of the covered employees' health coverage costs for the remainder of the calendar year.

Treatment of a Small Rebate: As a matter of administrative convenience, an employer that receives a small rebate is not required to directly provide employees with an allocable share of such amount. Instead, the employer may elect to use the employees' rebate for the benefit of plan participants in some other manner, such as by means of enhancements to a wellness program.

NOTE: The MLR requirements do not apply to self-funded benefits.

Newborns' and Mothers' Health Protection Act (NMHPA)

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean delivery. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). The group health plan does not need to provide the minimum period of coverage for a maternity stay if the mother and health care provider agree to an earlier discharge.

A group health plan cannot require a Covered Person or her attending provider to get permission (sometimes called prior authorization or pre-certification) for a hospital admission that is shorter than 48 hours for a vaginal delivery or 96 hours for a C-section delivery.

Women's Health and Cancer Rights Act (WHCRA)

The health benefits of most plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending physician and the patient: (1)

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reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce symmetrical appearance, (3) breast prostheses, and (4) physical complications of all stages of mastectomy, including lymphedemas.

Plan participants must be notified, upon enrollment and annually thereafter, of the availability of benefits required due to the WHCRA.

Notice of Right to Receive a Certificate of Creditable Coverage

Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a "certificate of creditable coverage" or "certificate of group health plan coverage," from the Plan Sponsor or its delegate. Proof of "creditable coverage" may reduce or waive pre-existing condition restrictions, if any, under a new coverage. If Plan coverage or COBRA continuation coverage terminates (including termination due to exhaustion of all lifetime benefits under the Plan), the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

Covered persons who are Medicare-eligible can keep their current coverage under the Health Savings Account (HSA) plan. However, because the coverage is non-creditable, the individual will have decisions to make about Medicare prescription drug coverage that may affect how much he pays for that coverage, depending on if and when he joins a drug plan. In making that decision, he should compare his current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in his area.

Over-the Counter (OTC) Medicines and Drugs

The Health Flexible Spending Account (Health FSA) benefit of a Section 125 Cafeteria Plan cannot reimburse expenses incurred for medicines or drugs purchased after December 31, 2010, unless the medicine or drug: (1) requires a prescription; (2) is available without a prescription (i.e., an over-the-counter or "OTC" drug) and the individual obtains a prescription; or (3) is insulin.

A prescription for a medicine or drug must be a written or electronic order that satisfies the legal requirements for a prescription in the state of purchase.

The above restrictions do not apply to over-the-counter items other than medicines and drugs (e.g., equipment, supplies, and medical devices such as bandages and thermometers). Such equipment, supplies and medical devices must, however, be for medical care and not merely beneficial to an individual's general health.

With some exceptions a debit card used to purchase health care services may no longer be used to purchase non-prescribed over-the-counter medicines and drugs.

Section 125 Plan - "Pretax" Premiums

The Employer has established a "cafeteria plan" under Internal Revenue Code Section 125 which allows for payment of the costs of certain welfare benefits to be paid on a pre-tax basis.

If an employee participates in the pre-tax premium benefit, his salary will be reduced by an amount equal to his share of the premium or coverage cost for the benefits he elects. The employer pays that "salary reduction amount" toward the cost of the benefits the employee has elected. The salary reduction amount is not included in the employee's taxable income for purposes of federal and most state and local income taxes. Employee also does not pay Social Security tax on the money, which means the salary reduction may reduce his wages reported for Social Security purposes and could, ultimately, reduce his Social Security benefit amount.

If an employee enrolls in the pre-tax premium benefit, his salary reduction election will be effective for the duration of the Plan Year. An employee cannot modify his salary reduction elections during a Plan Year unless he has an allowable change and then any modifications are subject to the plan's guidelines and IRS regulations. An IRS "allowable change" includes events such as marriage, divorce, birth or adoption of a child, death of a spouse or child, commencement or termination of employment, change from part-time to full-time employment or vice versa, other employment changes or changes in cost or coverage.

An employee should contact the employer's human resource department or personnel office if he wants additional information about how the pre-tax premium benefit works or how participation may affect his Social Security benefits.

Tax Relief for Dependent Child Coverage

If a Plan Sponsor's cafeteria (Section 125) plan is amended in accordance with the law, coverage provided to children who are under age 27 as of the end of the taxable year and excludible under Code Section 105(b) and 106 is a "qualified benefit" under the cafeteria plan rules – even if the child does not qualify as the Employee's tax

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dependent. Such coverage costs may be funded using pre-tax salary reduction.

A cafeteria plan "change in status" will include a nondependent child under age 27 becoming newly eligible for coverage or eligible for coverage beyond the date on which the child otherwise would have lost coverage. In such a case, the cafeteria plan will permit an election change in accordance with Section 125 mid-year election change allowances.

The employer will permit employees to immediately make pre-tax salary reduction contributions for accident or health benefits under the cafeteria for children who have not turned age 27 by the end of a taxable year.

Except as noted above, the cost(s) of coverage for an Employee's dependent who is not a "Tax Code dependent" (i.e., a dependent as defined in IRC § 152, as modified by Code section 105(b) and IRS Notice 2004-79) shall be paid by the Employee with after-tax contributions.

Tax Consequences of Domestic Partner Coverage

Please note that the tax treatment of domestic partner health care benefits is different than the tax treatment of health care benefits provided to a spouse. Most domestic partners and their children do not qualify under Internal Revenue Code section 125 as tax dependents of an employee. Under federal tax law, if an employee's domestic partner does not qualify as the employee's tax dependent, then the value of the domestic partner's coverage (and the partner's children's coverage) will be included in the employee's gross income, subject to federal income tax withholding and employment taxes, and will be reported on the employee's Form W-2. This includes any portion of the premium that the employer pays for the health coverage for the domestic partner and the partner's children. This also means that the employee's share of the contribution that covers the domestic partner and the partner's children will be paid using after-tax payroll deductions.

Rules regarding state tax consequences may vary from the federal tax treatment.

An employee should consult his own tax advisor as to the impact of providing coverage and benefits under the Plan to a domestic partner and the partner's children, and the application of Internal Revenue Code section 152.

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GENERAL PLAN INFORMATION

The following identifying information is disclosed to Plan participants to comply with the Employee Retirement Income Security Act (ERISA).

NAME OF PLAN (actual name)	Roger Williams University Welfare Plan
PLAN NUMBER	501
PLAN SPONSOR / EMPLOYER Address Phone Number	Roger Williams University One Old Ferry Road Bristol, RI 02809 401-254-3028
TYPE OF PLAN / TYPE OF BENEFITS	<p>This is a welfare plan providing the benefits reflected on the PLAN BENEFITS page(s) that follow. To the extent that the Plan includes group health benefits, the Plan is a group health plan which is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)</p> <p>NOTE: Some fringe (i.e., cafeteria/Section 125) benefits have been mentioned in this Wrap. Only the health flexible spending account is also a welfare benefit</p> <p>This SPD provides only a general description of Plan benefits. In each benefit section which follows, reference is made to one or more Benefit Documents. Additional benefit information is contained in those documents and is available to a Plan participant on request and without charge.</p>
TYPE OF ADMINISTRATION	(see the PLAN BENEFITS section for this information)
PLAN YEAR	January 1 Through December 31
PLAN SPONSOR TAX ID NUMBER	05-0277222
PLAN ADMINISTRATOR Business Address Business Phone Number	Roger Williams University One Old Ferry Road Bristol, RI 02809 401-254-3028
NAMED FIDUCIARY (see NOTE) Address	Roger Williams University One Old Ferry Road Bristol, RI 02809 401-254-3028
NOTE: For any Plan benefit that is fully insured (i.e., provided through a licensed insurance company), the insurance company is the Named Fiduciary for benefit determination purposes. See "Provider" in the following benefit sections for the identity of any such company.	
AGENT FOR SERVICE OF PROCESS Address Where Process May be Served	Office of General Counsel Roger Williams University 150 Washington Street Providence, RI 02903
Service of legal process may also be made on a Plan trustee (if any) or the Plan Administrator.	
ORIGINAL PLAN EFFECTIVE DATE	January 1, 2014
PARTICIPATING EMPLOYER(S)	Roger Williams University Roger Williams University School of Law

PLAN BENEFITS

("Component Benefits" of the Plan)

MEDICAL BENEFITS																			
PROVIDER Address Member Service Phone Numbers Website	Blue Cross Blue Shield of RI 500 Exchange Street, Providence, RI 02903 401-459-5000 www.bcbsri.com																		
The provider performs the following administrative services with respect to this benefit of the Plan: collection of premiums and payment of claims.																			
BENEFIT DOCUMENT(S)	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Group #1485-0001</td> <td style="width: 50%; border: none;">Group #1485-0008</td> </tr> <tr> <td style="border: none;">Group #1485-0002</td> <td style="border: none;">Group #1485-0009</td> </tr> <tr> <td style="border: none;">Group #1485-0003</td> <td style="border: none;">Group #1485-0010</td> </tr> <tr> <td style="border: none;">Group #1485-0004</td> <td style="border: none;">Group #1485-0011</td> </tr> <tr> <td style="border: none;">Group #1485-0005</td> <td style="border: none;">Group #1485-0012</td> </tr> <tr> <td style="border: none;">Group #1485-0006</td> <td style="border: none;">Group #1485-0013</td> </tr> <tr> <td style="border: none;">Group #1485-0007</td> <td style="border: none;">Group #1485-0014</td> </tr> <tr> <td style="border: none;">Group #0004B02-0001</td> <td style="border: none;">Group #1485-0015</td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">Group #4B02-0002</td> </tr> </table>	Group #1485-0001	Group #1485-0008	Group #1485-0002	Group #1485-0009	Group #1485-0003	Group #1485-0010	Group #1485-0004	Group #1485-0011	Group #1485-0005	Group #1485-0012	Group #1485-0006	Group #1485-0013	Group #1485-0007	Group #1485-0014	Group #0004B02-0001	Group #1485-0015		Group #4B02-0002
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Group #0004B02-0001	Group #1485-0015																		
	Group #4B02-0002																		
Plan participants should refer to the Benefit Documents for more complete information including detailed benefit schedules, the eligibility criteria, and circumstances that may result in the loss of benefits, etc. Benefit Documents are available without cost to any Plan participant or beneficiary who requests them.																			
FUNDING MEDIUM	Fully Insured – The benefit is fully insured by the name provider.																		
SOURCES OF CONTRIBUTIONS	Costs are shared – (i.e., employer and employee share the coverage cost). Costs are subject to change and employees will receive notice of any changes in advance.																		
TYPE OF ADMINISTRATION	Insurer Administration																		
ELIGIBLE PARTICIPANTS	Employees – working at least 30 hours per week. University Adjuncts teaching six (6) or more contact hours per semester in undergraduate day program. Children – under age 26																		
COVERAGE EFFECTIVE DATE	First of the month following the date of hire; University Adjuncts: First month qualified.																		

BASIC LIFE AND AD&D INSURANCE	
PROVIDER Address Member Service Phone Number Website	Sun Life Financial One Sun Life Executive Park, Wellesley Hills, MA 02481 800-786-5433 www.sunlife.com
The provider performs the following administrative services with respect to this benefit of the Plan: collection of premiums and payment of claims.	
BENEFIT DOCUMENT(S)	Policy # 219971
Plan participants should refer to the Benefit Documents for more complete information including detailed benefit schedules, the eligibility criteria, and circumstances that may result in the loss of benefits, etc. Benefit Documents are available without cost to any Plan participant or beneficiary who requests them.	
FUNDING MEDIUM	Fully Insured – The benefit is fully insured by the name provider.
SOURCE OF CONTRIBUTIONS	100% Employer-paid
TYPE OF ADMINISTRATION	Insurer Administration
ELIGIBLE PARTICIPANTS	Employees working at least 30 hours per week. University Adjuncts teaching six (6) or more contact hours per semester in the undergraduate day program.
COVERAGE EFFECTIVE DATE	First of the month following the date of hire; University Adjuncts: First month qualified.

LONG TERM DISABILITY INSURANCE	
PROVIDER Address Member Service Phone Number Website	Sun Life Financial One Sun Life Executive Park, Wellesley Hills, MA 02481 800-786-5433 www.sunlife.com
The provider performs the following administrative services with respect to this benefit of the Plan: collection of premiums and payment of claims.	
BENEFIT DOCUMENT(S)	Policy # 219971
Plan participants should refer to the Benefit Documents for more complete information including detailed benefit schedules, the eligibility criteria, and circumstances that may result in the loss of benefits, etc. Benefit Documents are available without cost to any Plan participant or beneficiary who requests them.	
FUNDING MEDIUM	Fully Insured – The benefit is fully insured by the name provider.
SOURCE OF CONTRIBUTIONS	100% Employer-paid
TYPE OF ADMINISTRATION	Insurer Administration
ELIGIBLE PARTICIPANTS	Employees working at least 30 hours per week.
COVERAGE EFFECTIVE DATE	First of the month following the date of hire

SHORT TERM DISABILITY INSURANCE	
PROVIDER Address Member Service Phone Number Website	Sun Life Financial One Sun Life Executive Park, Wellesley Hills, MA 02481 800-786-5433 www.sunlife.com
The provider performs the following administrative services with respect to this benefit of the Plan: collection of premiums and payment of claims.	
BENEFIT DOCUMENT(S)	Policy # 219971
Plan participants should refer to the Benefit Documents for more complete information including detailed benefit schedules, the eligibility criteria, and circumstances that may result in the loss of benefits, etc. Benefit Documents are available without cost to any Plan participant or beneficiary who requests them.	
FUNDING MEDIUM	Fully Insured – The benefit is fully insured by the name provider.
SOURCE OF CONTRIBUTIONS	100% Employer-paid
TYPE OF ADMINISTRATION	Insurer Administration
ELIGIBLE PARTICIPANTS	Employees working at least 30 hours per week.
COVERAGE EFFECTIVE DATE	First of the month following the date of hire

DENTAL BENEFITS	
PROVIDER Address Member Service Phone Number Website	Delta Dental of RI 10 Charles Street Providence, RI 02904-2208 800-843-3582 www.deltadentalri.com
The provider performs the following administrative services with respect to this benefit of the Plan: collection of premiums and payment of claims.	
BENEFIT DOCUMENT(S)	Group #1285-0005, 0009 Group #1285-0004, 0008, 0012 Group #1285-0001, 0002, 0006, 0007, 0010, 0011
Plan participants should refer to the Benefit Documents for more complete information including detailed benefit schedules, the eligibility criteria, and circumstances that may result in the loss of benefits, etc. Benefit Documents are available without cost to any Plan participant or beneficiary who requests them.	
FUNDING MEDIUM	Fully Insured – The benefit is fully insured by the name provider.
SOURCE OF CONTRIBUTIONS	Costs are shared – (i.e., employer and employee share the coverage cost). Costs are subject to change and employees will receive notice of any changes in advance.
TYPE OF ADMINISTRATION	Insurer Administration
ELIGIBLE PARTICIPANTS	Employees working at least 30 hours per week. University Adjuncts teaching six (6) or more contact hours per semester in the undergraduate day program.
COVERAGE EFFECTIVE DATE	First of the month following the date of hire

VOLUNTARY LONG TERM DISABILITY BENEFITS	
PROVIDER Address Member Service Phone Number Website	The Standard Insurance Company 1100 SW Sixth Ave, Portland, OR 97204 800-937-4783 www.standard.com
The provider performs the following administrative services with respect to this benefit of the Plan: collection of premiums and payment of claims.	
BENEFIT DOCUMENT(S)	Policy # 01290
Plan participants should refer to the Benefit Documents for more complete information including detailed benefit schedules, the eligibility criteria, and circumstances that may result in the loss of benefits, etc. Benefit Documents are available without cost to any Plan participant or beneficiary who requests them.	
FUNDING MEDIUM	Fully Insured – The benefit is fully insured by the name provider.
SOURCE OF CONTRIBUTIONS	100% Employee-paid
TYPE OF ADMINISTRATION	Insurer Administration
ELIGIBLE PARTICIPANTS	Employees working at least 30 hours per week.
COVERAGE EFFECTIVE DATE	First of the month following the application

VOLUNTARY LONG TERM CARE	
PROVIDER Address Member Service Phone Number Website	Genworth 6620 W. Broad Street, Richmond, VA 23230 800-456-7766 www.genworth.com
The provider performs the following administrative services with respect to this benefit of the Plan: collection of premiums and payment of claims.	
BENEFIT DOCUMENT(S)	Policy # 13073
Plan participants should refer to the Benefit Documents for more complete information including detailed benefit schedules, the eligibility criteria, and circumstances that may result in the loss of benefits, etc. Benefit Documents are available without cost to any Plan participant or beneficiary who requests them.	
FUNDING MEDIUM	Fully Insured – The benefit is fully insured by the name provider.
SOURCE OF CONTRIBUTIONS	100% Employee-paid
TYPE OF ADMINISTRATION	Insurer Administration
ELIGIBLE PARTICIPANTS	Employees working at least 20 hours per week.
COVERAGE EFFECTIVE DATE	The latter of the first of the month or on the date of application

VOLUNTARY ACCIDENT & HEALTH	
PROVIDER Address Member Service Phone Number Website	Aflac, Inc 1932 Wynnton Road, Columbus, Georgia 31999 800-992-3522 www.aflac.com
The provider performs the following administrative services with respect to this benefit of the Plan: collection of premiums and payment of claims.	
BENEFIT DOCUMENT(S)	Policy # C4551
Plan participants should refer to the Benefit Documents for more complete information including detailed benefit schedules, the eligibility criteria, and circumstances that may result in the loss of benefits, etc. Benefit Documents are available without cost to any Plan participant or beneficiary who requests them.	
FUNDING MEDIUM	Fully Insured – The benefit is fully insured by the name provider.
SOURCE OF CONTRIBUTIONS	100% Employee-paid
TYPE OF ADMINISTRATION	Insurer Administration
ELIGIBLE PARTICIPANTS	Employees working at least 30 hours per week.
COVERAGE EFFECTIVE DATE	The latter of the first of the month after 30 days of employment or on the date of application

BUSINESS TRAVEL ACCIDENT	
PROVIDER Address Member Service Phone Number Website	Chubb and Son – Federal Insurance Company 202 Hall's Mill Road, Whitehouse Station, NJ 08889-1600 908-903-2000 www.chubb.com
The provider performs the following administrative services with respect to this benefit: payroll and account management and payment of claims.	
BENEFIT DOCUMENT	Policy #99066342
Plan participants should refer to the Benefit Documents for more complete information including detailed benefit schedules, the eligibility criteria, and circumstances that may result in the loss of benefits, etc. Benefit Documents are available without cost to any Plan participant or beneficiary who requests them.	
FUNDING MEDIUM	Fully Insured – The benefit is fully insured by the name provider.
SOURCE OF CONTRIBUTIONS	100% Employer-paid
TYPE OF ADMINISTRATION	Insurer Administration
ELIGIBLE PARTICIPANTS	Employees working at least 30 hours per week.
COVERAGE EFFECTIVE DATE	Date of Hire

HEALTH REIMBURSEMENT ACCOUNT	
PROVIDER Address Member Service Phone Number Website	London Health Administrators 40 Commercial Way, East Providence, RI 02914 800-343-2236 www.londonhealthusa.com
The provider performs the following administrative services with respect to this benefit: payroll and account management and payment of claims.	
BENEFIT DOCUMENT	Policy # RWU502
Plan participants should refer to the Benefit Documents for more complete information including detailed benefit schedules, the eligibility criteria, and circumstances that may result in the loss of benefits, etc. Benefit Documents are available without cost to any Plan participant or beneficiary who requests them.	
FUNDING MEDIUM	Employer and Employee-funded
SOURCE OF CONTRIBUTIONS	Cost are shared – (i.e., employer and employee share the cost coverage cost). Cost are subject to change and employee will receive notice of any changes in advance.
TYPE OF ADMINISTRATION	Contract Administration
ELIGIBLE PARTICIPANTS	Employees working at least 30 hours per week. University Adjuncts teaching six (6) or more contact hours per semester in the undergraduate day program.
COVERAGE EFFECTIVE DATE	First of the month following the date of hire; University Adjuncts: First month qualified.

FLEXIBLE SPENDING ACCOUNT	
PROVIDER Address Member Service Phone Number Website	<p>London Health Administrators 40 Commercial Way, East Providence, RI 02914 800-343-2236 www.londonhealthusa.com</p> <p>The provider performs the following administrative services with respect to this benefit: payroll and account management and payment of claims.</p>
BENEFIT DOCUMENT	<p>http://www.rwu.edu/sites/default/files/downloads/hr/fsa-plan-document.pdf</p> <p>Plan participants should refer to the Benefit Documents for more complete information including detailed benefit schedules, the eligibility criteria, and circumstances that may result in the loss of benefits, etc. Benefit Documents are available without cost to any Plan participant or beneficiary who requests them.</p>
FUNDING MEDIUM	Employee-funded
SOURCE OF CONTRIBUTIONS	Employee Contribution
TYPE OF ADMINISTRATION	Contract Administration
ELIGIBLE PARTICIPANTS	Full time employees
COVERAGE EFFECTIVE DATE	Initial hire or benefit eligibility

OVERVIEW OF HEALTH CARE REFORM MANDATES

Effective on Plan Year anniversaries after 9-23-2010, an employer-sponsored group health plan must conform to the requirements of the Patient Protection and Affordable Care Act of 2010 - also referred to as federal Health Care Reform. In accordance with federal Health Care Reform, the following will generally apply. However, this is only an Overview. For example, the age 26 limit may apply to some plan benefits (e.g., "medical benefits") but might not be required for other benefits. The terms of the governing document (e.g., the "policy" or "certificate of coverage") will govern.

- **Eligibility for Children Extends to Age 26**

Dependent eligibility for children will extend to age 26 (i.e., child is eligible through age 25). The child need not: (1) reside with the employee or any other person, (2) be a student, (3) be a tax-code dependent of the employee, (4) be unmarried, or (5) be unemployed. Financial dependency upon the Employee or any other person is not a criteria for eligibility.

The following is an abbreviated summary of situations where a child may or may not be eligible for coverage under a group health plan:

a grandfathered group health plan is required to offer adult dependent coverage to a child who is under age 26 and who is not eligible for his own employer-sponsored coverage;

a grandfathered group health plan can refuse coverage to an adult Dependent child who is under age 26, if the child is eligible to enroll in his own employer-sponsored health plan or that of his spouse;

a non-grandfathered group health plan cannot refuse dependent coverage to an adult child, even if they are eligible for their own employer-sponsored group health coverage;

regardless of a plan's grandfathered status, an adult Dependent child who is under age 26 can stay on or come on to a parents' policy.

- **Lifetime and Annual Maximums will generally not apply to "Essential Health Benefits"**

Lifetime and annual dollar limits are not allowed for "essential health benefits." Essential health benefits include the following and the "scope of benefits will be equal to that of a typical employer plan":

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorders including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Preventative and wellness services and chronic disease management
- Pediatric services, including oral and vision care

No lifetime or annual dollar limits are allowed after January 1, 2014.

NOTE: Annual and lifetime dollar limits can apply to "stand-alone" or "excepted" dental and vision benefits. "Stand-alone" or "excepted" benefits are benefits that are not a part of a package of health care benefits (e.g., a group health plan offering medical, dental and vision benefits for a flat cost) but that are selected by the employee for a separate cost.

- **Emergency Services**

For a non-grandfathered plan, benefits for emergency services must be provided at in-network benefit levels, regardless of whether the provider is or is not a network provider.

- **Pre-existing Condition Restrictions**

Pre-existing condition restrictions cannot be applied to persons under the age of 19.

NOTE: For Plan Years on or after January 1, 2014, preexisting condition restrictions can no longer apply.

OVERVIEW OF HEALTH CARE REFORM MANDATES

- **Preventive Care Benefits**

For a non-grandfathered plan, the following preventive care benefits must be provided with no cost sharing (i.e., paid at 100%) when Network providers are used:

- evidence-based items or services with a rating of “A” or “B” in the current recommendations of the U.S. Preventive Services Task Force
- immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved
- for infants, children and adolescents, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
- for women, additional preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration
- for women, the recommendations issued by the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009

- **Primary Care Physician**

For a non-grandfathered plan, if a plan benefit requires the designation of a primary care physician (PCP), an enrollee must be allowed to designate any network physician as their primary care physician.

- **Claims Appeals Procedures for Non-grandfathered Benefits**

Claims appeal procedures are as reflected in each respective Benefit Document that is a part of the client’s plan of benefits. The Benefit Document should be examined for those procedures.

The following group health claims information is part of Health Care Reform and (with the exception of the Federal external appeals process) it applies to non-grandfathered benefits only. This is an abbreviated summary. More complete information can be found in Technical Release No. 2010-02.

Internal Claims and Appeals Process - A non-grandfathered group health plan must have internal claims and appeals procedures that satisfy the requirements of the ERISA claims regulations. This requirement also applies to governmental plans and church plans. In addition, the internal appeals procedures, regardless of ERISA status, must also include:

- An Expanded Definition of “Adverse Benefit Determination” - In addition to denial, reduction, or termination of, or a failure to provide or make payment for a benefit, an adverse benefit determination will include a rescission of coverage as defined under the Patient Protection and Affordable Care Act.
- Reduced Timeframe for Urgent Care Determinations - The plan must notify a claimant of an urgent care claim determination (whether adverse or not) as soon as possible, but no more than 24 hours after receiving the claim.

NOTE: The effective date of the above requirement is subject to the Department of Labor’s Technical Release No. 2011-01. It applies on the Plan Year anniversary beginning on or after January 1, 2012.

- Additional Information to Claimant - A claimant appealing an adverse benefit determination may request access to, and copies of, documentation relevant to the claim, which must be provided free of charge. Also, if a plan considers, relies on or generates any new evidence during the appeal process, or bases its determination on appeal on a new rationale, it must furnish the new evidence or rationale to the claimant as soon as possible and free of charge. This documentation must be provided sufficiently in advance of the final determination so that the claimant has a reasonable opportunity to respond before the final determination is made.
- Avoidance of Conflicts of Interest - The plan is required to ensure that claims and appeals are adjudicated by individuals who are independent and impartial. Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to a claims adjudicator or medical expert cannot be based upon the likelihood such individual will deny a claim.
- Culturally and Linguistically Appropriate Notices – Notices must be provided in a culturally and linguistically appropriate manner, as required by the statute and as set forth in paragraph (e) of the 2010 interim final regulations.

OVERVIEW OF HEALTH CARE REFORM MANDATES

The plan must provide notices to claimants in a non-English language upon request, if the number of plan participants who are literate in that language (i.e., can read only in that non-English language) meets certain thresholds:

- For a plan with fewer than 100 participants, non-English notices must be provided upon request if at least 25% of all plan participants are literate only in the same non-English language.
- For a plan with 100 or more participants, non-English notices must be provided upon request if the lesser of 500 participants or 10 percent of all plan participants are literate only in the same non-English language.

Once the applicable threshold (above) has been met:

- English versions of all notices must contain a prominent statement in the non-English language offering the notice in the Non-English language.
- A claimant who has requested a non-English notice must receive all subsequent notices in that language.
- Any customer assistance process, such as a hotline, offered for filing claims and appeals must also be provided in the non-English language.

NOTE: The effective date of the above requirement is subject to the Department of Labor's Technical Release No. 2011-01. It applies on the Plan Year anniversary beginning on or after January 1, 2012.

- Content of Notices - In addition to the information required by the ERISA claims regulations, a notice of an adverse benefit determination must include the following:
 - date of service, provider, and claim amount (if applicable)
 - diagnosis code, treatment code and denial code (and their meanings)
 - a description of any standard (e.g., medical necessity) used in denying the claim, and in the case of a final internal adverse determination, the description must include a discussion of the decision
 - a description of available internal appeals and external review processes (including how to initiate an appeal)
 - a statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist with claims, appeals and external reviews.

NOTE: The effective date of the above requirement is subject to the Department of Labor's Technical Release No. 2011-01. It applies on the Plan Year anniversary beginning on or after January 1, 2012.

- Continued Coverage Pending Appeals Outcome - The plan must continue coverage during the appeal process, pending the outcome of the review. Where the plan has previously approved an ongoing course of treatment for a specified period of time or number of treatments, it cannot reduce the period/number without first providing the claimant advance notice and an opportunity to appeal.
- Failure to Adhere - If the Plan fails to strictly adhere to all of the requirements of the 2010 interim final regulations and Technical release 2011-01, the Claimant is deemed to have exhausted the Plan's internal claims and appeals process, regardless of whether the Plan asserts that it has substantially complied, and the Claimant may initiate any available external review process or remedies available under ERISA.

NOTE: The effective date of the above requirement applies on the Plan Year anniversary beginning on or after January 1, 2012.

External Review Processes - A non-grandfathered and self-funded group health plan is subject to the federal external review process. A self-funded plan must comply with one of the interim ("safe harbor") compliance methods:

- The plan must follow the procedures set forth in Technical Release No. 2010-01. These procedures are based on the Uniform Health Care External Review Model Act issued by the National Association of Insurance Commissioners; or

OVERVIEW OF HEALTH CARE REFORM MANDATES

- The plan must be in a state that chooses to expand access to its state external review process to self-funded plans that are not subject to the applicable state laws, and the plan complies voluntarily with the provisions of the state's external review process.

In accordance with Technical Release No. 2010-01, a group health plan must let a claimant file a request for an external review with the plan if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination.

External Review Organization(s) - To conduct an external review, the group health plan must assign the external review process to an independent review organization (an "IRO") that is accredited by a nationally recognized accrediting organization. The plan must take action against bias to ensure independence.

The plan must contract with at least three IROs and must rotate claims assignments among them. The IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The assigned IRO must provide written notice of the final external review decision within 45 days after receiving the request for the external review. The notice must be delivered to the claimant and to the plan.

Expedited External Review - Expedited external review procedures are to be provided for cases where completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize his or her ability to regain maximum function. For an expedited review, the IRO must provide notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the plan.

- **Summary of Benefits & Coverage (SBC)**

The Affordable Care Act (the Act) and the Final Rule requires that a "Summary of Benefits & Coverage" (SBC) be provided to applicants, enrollees and policyholders or certificate holders.

The Act and Final Rule places the responsibility to provide an SBC on: (1) the issuer for delivery to an insured group health plan, (2) the health insurance issuer and the group health plan (including the Plan Administrator as defined by ERISA), or (3) the group health plan or designated administrator of the plan as that term is defined under ERISA. The Final Rule does not include an exemption for large or self-insured plans.

The SBC is a 4-page (double sided) summary of benefits under the Plan. The Plan must use the template adopted by the agencies, which includes fill-in-the-blank boxes about the types of benefits covered, deductible, and other cost-sharing. The template and instructions, along with a sample completed SBC, can be found at www.dol/ebsa.

- **Rescission of Coverage**

The plan may not rescind an individual's coverage under the plan (e.g., cancelling coverage after a Covered Person has submitted a claim). However, the plan may rescind coverage if a Covered Person commits fraud or makes an intentional misrepresentation of a material fact.

IMPORTANT: THE ABOVE IS ONLY A SUMMARY. IN THE EVENT OF ANY CONFLICT BETWEEN THIS SECTION AND THE TERMS OF THE ACT, THE TERMS OF THE ACT WILL GOVERN.

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QMCSO PROCEDURES

(A "QMCSO" is a QUALIFIED MEDICAL CHILD SUPPORT ORDER)

These procedures ("QMCSO Procedures") set forth the steps to be taken by the Plan Administrator in the event the Plan Administrator receives a "Medical Child Support Order" with respect to a child of a Plan participant **or** a National Medical Support Notice (an "NMSN") issued pursuant to Section 401(b) of the Child Support Performance and Incentive Act of 1998. These QMCSO Procedures shall be followed by the Plan Administrator for determination by the Plan Administrator of whether the Medical Child Support Order or National Medical Support Notice is a "Qualified Medical Child Support Order" ("QMCSO") within the meaning of Section 609 of the Employee Retirement Income Security Act of 1974 ("ERISA"). "Child" refers to any natural child of a Plan participant, or any child adopted by or placed for adoption with a Plan participant.

A "Medical Child Support Order" is any judgment, decree or order (including approval of a settlement agreement), issued by a court of competent jurisdiction, or issued through an administrative process established under State law which has the force and effect of law under applicable State law, and which is made pursuant to Social Security Act Section 1908 with respect to the Plan, **or** which:

- provides for child support with respect to a child of a Participant under the Plan, or provides for health benefit coverage to the child under the Plan;
- is made pursuant to a State domestic relations law (including community property law); and
- relates to benefits under the Plan.

The Plan Administrator will follow these QMCSO Procedures with respect to a medical child support order or a proposed medical child support order (an "Order") or with respect to a National Medical Support Notice (an "NMSN") received by the Plan.

Receipt of Order or NMSN - Upon receiving an Order or National Medical Support Notice, the Plan Administrator will take the following steps:

- The Plan Administrator will send a letter acknowledging receipt of the Order or NMSN to:
 - the employee Plan participant; and
 - the entity(ies) designated in the Order or NMSN to receive acknowledgement for the child (i.e., each named child or the named State or local official).
- The Plan Sponsor will review the Order or NMSN to make certain that it:
 - specifically provides for a dependent (or dependents) to receive benefits under the group health coverage(s);
 - provides: (1) the name and last known mailing address of the employee Plan participant, and (2) the name and last known mailing address of each child covered by the Order or NMSN **or** the name and mailing address of a State or local official;
 - provides a reasonable description of the health care coverage to be provided by the Plan or the manner in which the coverage can be determined. The Order or NMSN cannot require a Plan to provide any benefit or option that is not otherwise provided;
 - specifies the time period to which the Order or NMSN applies;
 - names each group health benefit to which the Order or NMSN applies.
- The employee Plan participant may be required to provide necessary identifying information about the child(ren), such as social security number(s), so that the Plan Administrator can comply with the requirements of the law.
- If an Order, upon completion of its review, the Plan Administrator will send a letter to the employee Plan participant and each affected child (or the designated State or local official) advising whether or not the Order has been determined to be a qualified Order (a "QMCSO"), including the specific reasons for denial if the Order is determined not to be a QMCSO. If the Order is determined to be a QMCSO, the Plan Administrator shall commence benefit coverage on the date set forth in the QMCSO (or as soon as administratively feasible if the QMCSO calls for immediate commencement of benefit coverage).

QMCSO PROCEDURES

- If an NMSN, within 40 days of receipt of the NMSN the Plan Administrator will notify the State agency issuing the NMSN whether the NMSN is determined to be a QMCSO, including the specific reasons for denial if the NMSN is determined not to be a QMCSO. If the NMSN is determined to be a QMCSO, the Plan Administrator will notify the State agency issuing the NMSN whether coverage of the child is available under the terms of the group health care programs offered under the Plan and, if such coverage is available, notify such State agency whether such child is covered under the Plan. If such coverage is available and the child is not covered, the Plan Administrator will notify such State agency of any steps to be taken by the custodial parent (or by a State official substituted for the name of such child) to effectuate such coverage.
- If the Order or NMSN is determined to be qualified, each child (or the designated State or local official) is entitled to all reporting and disclosure requirements to which other Plan participants are entitled under ERISA. Any child affected by the Order or NMSN is also permitted to designate a representative to receive copies of any notices regarding this matter or any coverage or benefits matters. Any such designation should be sent to the Plan Administrator.

OTHER ERISA INFORMATION

ERISA (Employee Retirement Income Security Act) requires that the following information be included in a Summary Plan Description of an employee welfare plan. For ease of reference, the information has been given titles and is alphabetized. A title is not intended to change the meaning of any provision.

Benefits

This SPD provides only a general description of Plan benefits. However, in the **PLAN BENEFITS** section(s), one or more "Benefit Documents" are referenced. More benefit information is contained in those documents and the documents are available to a Plan participant on request and without charge. For a health benefit, the information shall include:

cost-sharing provisions, including premiums, deductibles, coinsurance, and copayment amounts for which a covered person may be responsible;

any annual, lifetime or other benefit maximums;

other items of important information etc. as may apply to a particular benefit;

the extent to which preventive services are covered;

whether, and under what circumstances, coverage is provided for existing and new drugs, medical tests, devices and procedures;

any limits applicable to obtaining emergency medical care;

any preauthorization or utilization review requirements for obtaining a benefit or service under the Plan.

Claims Procedures

Procedures for group health and disability claims must be provided to Plan participants automatically and without charge. Such procedures may be included in the applicable Benefit Document or may be provided in one or more separate documents that can be obtained from the Plan Sponsor or Plan Administrator. Briefly, claims procedure information includes:

procedures for obtaining preauthorizations, approvals or utilization review decisions in the case of group health plan services or benefits;

procedures for filing claim forms, providing notifications of benefit determinations and reviewing denied claims; and

applicable time limits, and remedies available under a component benefit of a Plan for the redress of claims which are denied in whole or in part.

Questions regarding claim procedures should be directed to the Plan Sponsor/Plan Administrator.

Eligibility and Participation Requirements

See each benefit listing within the **PLAN BENEFITS** section for summary information as to who may participate in the Plan's benefits. The applicable Benefit Document should be consulted for more complete information. Notwithstanding the foregoing, an individual shall be ineligible to participate in the Plan if such individual is not reported on the payroll records of the Employer as a common law employee. Ineligible employees include those individuals who are temporary employees, independent contractors or consultants. Any individuals who are designated (at the time such individuals are performing services for the Employer) as any of the foregoing on the records of the Employer or in agreements with the Employer shall be ineligible to participate in the Plan, regardless of whether any such individual is later determined to be a common law employee by the Internal Revenue Service, a court or other regulatory authority.

Fiduciary(ies) / Named Fiduciary

Plan fiduciaries include the Plan Administrator and any other person or entity that exercises fiduciary discretion and authority under the Plan as prescribed in ERISA, but only with respect to their specific fiduciary responsibilities. Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

A Named Fiduciary with regard to a component benefit is an entity (e.g., an insurer) with authority to make claims decisions and/or decisions on claims appeals.

Funding

Funding Medium - The identity of any funding medium, including any insurance company, trust fund, or other entity that maintains a fund on behalf of a Plan or through which a Plan is funded or benefits are provided is shown in the **PLAN BENEFITS** section with respect to each component benefit.

Contributions - From time to time, the Plan Sponsor will evaluate the costs of Plan benefits and determine the amounts to be contributed by the employer and the amounts to be contributed (if any) by each employee. The employer shall contribute the difference between the amount employees contribute and the premiums or full contribution cost for the benefit. Any experience credits or refunds under a group contract shall be applied first to reimburse the employer for its contributions, unless otherwise provided in the contract or required by applicable law.

Loss of Benefits

The following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit a Plan participant or beneficiary might otherwise reasonably expect a Plan to provide based on the benefit description:

- an employee's cessation of active service for the employer;
- a Plan participant's failure to pay his/her share of the coverage cost, if any, in a timely manner;
- a dependent ceases to meet the eligibility requirements (e.g., a child reaches a maximum age limit or spouses divorce);
- a Plan participant is injured and expenses for treatment may be paid by or recovered from a third party (e.g., by exercise of subrogation or reimbursement rights);
- a claim for benefits is not filed within the required time limits;
- an amendment to the Plan by the Plan Sponsor that reduces or eliminates a benefit, or the termination of the Plan by the Plan Sponsor;
- deliberate falsification or misrepresentation of an individual's eligibility for benefits.

Network Providers

Where a health benefit involves the use of "network providers" (also sometimes referred to as "PPO", "EPO" or "preferred providers"), Plan participants will receive listings of such providers without charge. The listings may be provided in one or more separate documents or by electronic document access via the Internet.

Where a network is involved, a Benefit Document will include provisions governing the use of such providers, primary care providers or providers of specialty services, the composition of the network and whether and under what circumstances coverage is provided for emergency and out-of-network services.

Purpose of the Plan(s)

A Plan is established for the exclusive benefit of eligible employees.

Termination or Amendment of the Plan(s)

The Plan Document defines the right and obligations of the Plan Administrator with regard to amending or terminating the Plan.

NOTE: See "Health Insurance Portability and Accountability Act" in the **FEDERAL LAWS AFFECTING HEALTH & WELFARE BENEFITS** for more information on amendment procedures.

Utilization Review

The medical benefits offered by a Plan may include utilization review programs - see the appropriate Benefit Document(s) in the list of **PLAN BENEFITS**. A utilization review program usually requires that an employee or Plan participant (or a hospital or physician on his/her behalf) contact an independent organization prior to hospitalization or prior to the receipt of other health care services or supplies. The organization then reviews the proposed treatment to make certain that the type or level of care is appropriate and medically necessary. Failure to contact or to comply with the recommendations of the utilization review organization may result in reduced benefits.

FEDERAL LAWS AFFECTING HEALTH & WELFARE BENEFITS

Certain federal laws apply to group health programs in addition to those addressed in the **IMPORTANT NOTICES**. Many of these laws are amendments to ERISA. The following is an overview of the laws and their impact. The effect of these laws on Plan benefits is as reflected in the various Benefit Documents (i.e., the certificates or evidences of coverage) provided to Plan participants.

Family and Medical Leave Act (FMLA)

If an employer is subject to the Family and Medical Leave Act (FMLA) and a covered employee ceases active employment due to an employer-approved leave in accordance with the requirements of FMLA, coverage will be continued under the same terms and conditions that would have applied had the employee continued in active employment. Contributions will remain at the same employer/employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other employees in the same classification). When the need for leave is foreseeable, an employee is required to provide at least 30 days advance notice.

An employer may require certification from a health care provider to support a claim for leave - but if an employer asks one employee for proof of a serious illness, the employer must ask all employees for equivalent certification.

In accordance with the FMLA, an employee is entitled to continued coverage if he/she: (1) has worked for the employer for at least twelve months, (2) has worked at least 1,250 hours (25 hours per week) in the year preceding the start of the leave, and (3) is employed at a worksite where the employer employs at least fifty employees within a 75-mile radius.

Except as noted (see NOTES, below), continued coverage under the FMLA is allowed for up to 12 workweeks of unpaid leave in any 12-month period. Leave can be taken intermittently, is subject to employer approval, and does not result in a reduction in the total amount of leave to which the employee is entitled. Any such leave must be for one or more of the following reasons:

the birth of an employee's child and in order to care for the child;

the placement of a child with the employee for adoption or foster care;

to care for a spouse, child or parent of the employee where such relative has a serious health condition;

employee's own serious health condition that makes him/her unable to perform the functions of his or her job;

the employee has a "qualifying exigency" (as defined by DOL regulations) arising because the employee's spouse, son, daughter or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation (a specified military operation).

When a husband and wife work for the same employer, the total amount of leave that they may take is limited to 12 weeks if they are taking leave for the birth or adoption of a child or to care for a sick parent.

An employee may elect or an employer may require an employee to substitute categories of paid leave, such as accrued time off or vacation time, for any part of the 12-week period.

The employer maintains existing health coverage for the duration of the leave and at the levels and under the conditions that would have been present if employment was continuous. An employer can ask the employee to cover his/her share of the cost of coverage.

Upon return to work from an approved leave, an employee must be restored to his original or an equivalent position with equivalent benefits, pay, and all other terms and conditions of employment. However, an employee in the highest paid 10% of salaried employees may be denied job restoration to prevent substantial and grievous economic injury to the employer.

NOTES: An eligible employee will be entitled to take up to a combined total of 26 workweeks of FMLA leave during a single 12-month period where the employee is a spouse, son, daughter, parent or next of kin (i.e., nearest blood relative) of a covered servicemember. A "covered servicemember" is a member of the Armed Forces (including the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is an outpatient, or is on the temporary disability retired list, for a "serious injury or illness" (an injury or illness incurred in line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform his or her duties).

FEDERAL LAWS AFFECTING HEALTH & WELFARE BENEFITS

The FLMA does not supersede any State or local law, collective bargaining agreement, or employment benefit plan providing greater employee family leave rights, nor does it diminish an employer's capacity to adopt more generous family leave policies.

GINA (the Genetic Information Nondiscrimination Act) requires employers who seek medical certification in support of leave or accommodation requests - including FMLA leave - to provide new disclosures or risk violating GINA. GINA prohibits discrimination and harassment based upon genetic information, bars an employer from acquiring genetic information except in certain narrow circumstances, and requires employers to keep confidential any genetic information they may have.

The above is a summary of FMLA requirements. An employee can obtain a more complete description of his/her FMLA rights from the Plan Sponsor's benefits department. Any Plan provisions that are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

Genetic Information Non-Discrimination Act (GINA)

GINA (Genetic Information and Non-discrimination Act) was enacted on May 21, 2008 and applies to a group health plan on its Plan Year beginning after May 21, 2009. The Act makes it illegal for group health plans to deny coverage or charge a higher rate or premium to an otherwise healthy individual found to have a potential genetic condition or genetic predisposition towards a disease or disorder. The Plan's eligibility and coverage provisions exclude denial of benefits or increased rates due to a potential or predisposition of a genetic condition of covered employees and their families.

The Act defines genetic information as that obtained from an individual's genetic test results, as well as genetic test results of family members and the occurrence of a disease or disorder in family members.

Healthcare Reform (H.R. 3590, the Patient Protection and Affordable Care Act)

Effective for Plan Years beginning after September 23, 2010, new requirements will apply to an employer's group health plan. Federal Health Care Reform applies to fully-insured, group and individual health plans and self-funded group health plans. See the section entitled **Overview of Health Care Reform Mandates** for information. The full requirements under the Act will apply for Plan years beginning on or after January 1, 2014.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA amended ERISA and applies to the health benefits of a Plan. HIPAA was enacted, among other things, to improve portability and continuity of health care coverage. The following are summaries of HIPAA's primary impact on group health plans.

- **Non-Discrimination Due to Health Status**

Application to Eligibility - Any rule for eligibility that discriminates based on a "health factor" of an individual or a dependent of that individual is prohibited. For instance, a Plan is prohibited from containing an actively-at-work requirement that is based on a health factor of an employee. An exception is made with regard to an employee's first day of work (e.g., if an individual does not report to work on his/her first scheduled work day he/she need not be covered and any waiting period for coverage need not begin). Similarly, a dependent cannot be refused enrollment or coverage based on a "health factor" such as confinement in a health care facility.

An individual's engagement in recreational activities (including high-risk recreational activities) cannot be used to deny an individual enrollment in a Plan.

A "health factor" means any of the following:

- a medical condition (physical or mental) including conditions arising out of acts of domestic violence
- claims experience
- receipt of health care
- medical history
- evidence of insurability
- disability
- genetic information

"Rules for eligibility" include, but are not limited to, rules relating to:

- enrollment;
- the effective date of coverage;

FEDERAL LAWS AFFECTING HEALTH & WELFARE BENEFITS

waiting (or affiliation) periods;

late and special enrollment;

eligibility for benefit packages (including rules for individuals to change their selection among benefit packages);

benefits (including rules related to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, co-payments and deductibles);

continued eligibility; and

terminating coverage of any individual under a Plan.

Application to Benefits - Any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual Plan participants or beneficiaries based on any health factor of the participants or beneficiaries. Similarly, any amendment limiting benefits under a Plan based on a health factor must be universally applicable to all individuals. A Plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the Plan and made effective no earlier than the first day of the first Plan Year after the amendment is adopted is not considered to be directed at individual participants and beneficiaries.

- **Special Enrollment Rights & Mid-Year Election Change Allowances**

An individual who enrolls in accordance with HIPAA's "Special Enrollment Rights" is not a "late enrollee" as that term may apply to any pre-existing condition limitations of a Plan or a Component Benefit. The following is an overview of such rights and the minimum requirements of the law.

Entitlement to Enroll Due to Loss of Other Coverage - An individual who did not enroll when previously eligible, will be allowed to apply for coverage at a later date if:

he/she was covered under another group health plan or other health insurance coverage at the time coverage was initially offered or previously available to him/her. "Health insurance coverage" means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;

the employee stated in writing at the time a prior enrollment was offered or available that other coverage was the reason for declining enrollment. However, this only applies if the Plan Sponsor required such a written statement and provided the person with notice of the requirement and the consequences of failure to comply with the requirement;

the individual lost the other coverage as a result of a certain event such as, but not limited to:

- loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
- loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual);
- loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
- loss of eligibility when an individual incurs a claim that would meet or exceed a lifetime limit on all benefits. An individual has a special enrollment right when a claim that would exceed a lifetime limit on all benefits is incurred, and the right continues at least until thirty (30) days after the earliest date that a claim is denied due to the operation of the lifetime limit;

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- loss of eligibility when a plan no longer offers any benefits to a class of similarly situated individuals. For example, if a plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility, even if the plan continues to provide coverage to other employees;
- loss of eligibility when employer contributions toward the employee's or dependent's coverage terminates. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer;
- loss of eligibility when COBRA continuation coverage is exhausted;
- loss of eligibility (on or after April 1, 2009) under Medicaid or CHIP ("Children's Health Insurance Program" which is known as "Healthy Families" in California) or the date the individual becomes eligible for premium assistance under Medicaid or CHIP; and the employee requested Plan enrollment within: (1) 60 days with regard to loss of eligibility for Medicaid or CHIP, or (2) 30 days of loss of eligibility in other instances.

If the above conditions are met, coverage will be effective not later than the first day of the first calendar month that begins after the date on which the completed application was received.

NOTE: For a dependent to enroll under the terms of this provision, the employee must be enrolled or must enroll concurrently.

Entitlement to Drop Due to CHIP Eligibility - If an employee's child(ren) become eligible for CHIP (known as "Healthy Families" in California), employee has the ability to drop the child(ren) from the group health coverage.

Entitlement to Enroll Due to Acquiring New Dependent(s) - If an employee acquires one (1) or more new eligible dependents through marriage, birth, adoption, or placement for adoption (as defined by federal law), he/she will have at least thirty (30) days from the date acquired (the "triggering event") to apply for their coverage and coverage will be effective as follows - see NOTE:

where employee's marriage is the "triggering event" - not later than the first day of the first calendar month after the enrollment request is received; and

where birth, adoption or placement for adoption is the "triggering event" - on the date of the event (i.e., concurrent with the child's date of birth, date of placement or date of adoption). The "triggering event" date for a newborn adoptive child is the child's date of birth.

NOTE: For a newly-acquired dependent to be enrolled under the terms of this provision, the employee must be enrolled or must enroll concurrently. If the newly-acquired dependent is a child, the spouse is also eligible to enroll. However, other dependent children who were not enrolled when first eligible are not considered to be "newly acquired" and may be subject to the late enrollment provisions of the health coverages.

- **Pre-Existing Condition Restrictions** (not applicable to persons under age 19)

Definition - For medical benefit purposes, a "pre-existing condition" is an illness or injury for which medical advice, diagnosis, care or treatment was recommended or received ("treatment" includes taking drugs or medicines) during a period which, by law, cannot exceed six (6) months before the individual's enrollment date. An individual's "enrollment date" is his/her first day of coverage, or if earlier, the first day of the waiting period for such coverage. A pregnancy cannot be considered a pre-existing condition, regardless of the date of conception, diagnosis, or first treatment. Genetic information is not a pre-existing condition in the absence of a diagnosis of a condition related to the genetic information.

Coverage Restrictions - Except for persons under age 19, a medical benefits program may limit or deny benefits for a pre-existing condition. Any such benefit restrictions must be removed not later than the 12-month anniversary from the individual's enrollment date (i.e., 12 months from his/her first day of medical coverage, or if earlier, 12 months from the first day of the waiting period for such coverage).

However, for an individual who is a late enrollee (i.e., who is permitted to enroll after his/her initial eligibility period), a pre-existing condition can be restricted for up to a period of eighteen (18) consecutive months from his/her enrollment date.

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The pre-existing time limits may be credited (i.e., reduced) if an individual had prior coverage. See "Allowance for Prior Creditable Coverage" below. A Plan cannot reduce the length of a pre-existing condition period based on the absence of claims or receipt of health care services.

- **Allowance for Prior "Creditable Coverage"**

An individual who transfers to health plan coverage from another plan of "creditable coverage" within 63 days (i.e., with not more than 62 days of non-coverage, not counting any days applied toward waiting period requirements), has a right to demonstrate "creditable coverage" and to request a certificate of creditable coverage from the prior health plan(s). The Plan Sponsor will help any such individual in obtaining such certificate(s). An individual also has the right to demonstrate creditable coverage through the presentation of documentation or other means where a certificate of creditable coverage cannot be obtained from the prior health plan(s).

If the prior coverage is determined to be "creditable coverage", the enrollee will be credited with time covered under such prior plan(s) toward the time limits of any pre-existing condition limitations that may apply.

"Creditable coverage" includes coverage under a group health plan (including a governmental or church plan), individual health insurance coverage, Medicare (other than coverage solely under § 1928 of the Social Security Act – the program for distribution of pediatric vaccines), Medicaid, military-sponsored health care, a program of the Indian Health Services, a State health benefits risk pool, the Federal Employees Health Benefit Program, The State Children's Health Insurance Program, a public health plan as defined in regulations (i.e., any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan), and a health benefit plan under the Peace Corps Act. A coverage can be "creditable coverage" even if such coverage remains in effect.

- **Source of Injury Restrictions** - A Plan cannot exclude benefits for injury which results from a medical (physical or mental) condition or domestic violence. For example, any restriction for injury resulting from criminal activity or self-inflicted injury will not apply where such injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g. depression). Similarly, an injury sustained while intoxicated may not be excluded from coverage if the injury resulted from alcoholism (a medical condition).
- **Wellness Programs** - A Plan cannot impose higher cost-sharing factors (i.e., deductibles, copayments, etc.) on individuals based on an adverse health factor (e.g., smoking), unless the benefit differential is based on participation in an employer's bona fide wellness program as defined by IRS Regulations Section 54.9802-1(f). Participation in such program must waive any adverse benefit differentials.

Mental Health & Substance Abuse Parity

Concurrent with a Plan Year anniversary on or after October 3, 2009, The Emergency Economic Stabilization Act of 2008 requires that a Plan providing coverage for mental health conditions or substance abuse/dependency must provide coverage for such conditions on par with the other medical surgical coverages it offers. No special treatment limitations or financial requirements can be applied. "Treatment limitations" include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. "Financial requirements" includes deductibles, co-pays, percentage sharing provisions and out-of-pocket expenses. "Covered same as Sickness" also extends to medical management matters (i.e., utilization review program requirements). This legislation does not apply to employers with fewer than 51 employees.

For mental health care and prior to the Plan Year anniversary as determined above, federal law requires that any mental health care coverage provided by a group health plan may not be subject to annual or lifetime dollar maximums that are less than those applied to any other sickness.

Omnibus Budget Reconciliation Act of 1993

OBRA 1993 requires that an eligible dependent child of an employee will include a child who is adopted by the employee or placed with him/her for adoption prior to age 18 and a child for whom the employee or covered dependent spouse is required to provide coverage due to a Medical Child Support Order (MCSO) which is determined by the Plan Sponsor to be a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and having the force and effect of law under state law and which satisfies the QMCSO requirements of ERISA (section 609(a)).

See the **QMCSO Procedures** section, if any, for more information. If no such section is included, a copy of the QMCSO procedures can be obtained, without charge, from the Plan Administrator.

Pregnancy Discrimination Act

Federal law requires that an employer provide coverage for pregnancy expenses in the same manner as any other sickness. This requirement applies to pregnancy expenses of an employee or a covered dependent spouse of an employee.

Privacy Rules, Security Standards & Breach Notification Rules

To the extent required by law, the Plan is amended and will comply with: (1) the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rules") of the Health Insurance Portability and Accountability Act (HIPAA), and (2) the HIPAA Security Standards with respect to electronic Protected Health Information.

HIPAA's Privacy Rules and Security Standards apply to group medical and dental benefits as well as health flexible spending account (Health FSA) benefits offered through a Section 125 cafeteria plan.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

The 2009 breach notification regulations and the Health Information Technology for Economic and Clinical Health (HITECH) Act, require HIPAA covered entities and their business associates to provide notification to an affected individual following a breach of unsecured protected health information. Such individual notification must be provided within a reasonable period of time and in no case later than 60 days following the discovery of a breach. To the extent possible, such affected individual must also be provided with a description of the breach, a description of the types of information that were involved in the breach, the steps the individual should take to protect themselves from potential harm, a brief description of what the covered entity is doing to investigate the breach, mitigate the harm, and prevent further breaches, as well as contact information for the covered entity. More information is available on the U.S. Department of Health & Human Services' website.

NOTES: The Privacy Rules requirements do not apply to "summary health information" which is provided only for the purpose of obtaining premium bids or for modifying or terminating the Plan. "Summary health information" is health-related information that is in a form that excludes individual identifiers such as names, addresses, social security numbers or other unique patient-identifying numbers or characteristics.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an employee entering military service.

An employee who is ordered to active military service is (and the employee's eligible Dependent(s) are) considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA (except that COBRA applies to employer-sponsored group health plans with 20 or more employees, while USERRA applies to all employers). Under either option, the employee retains the right to re-enroll in the Plan in accordance with the stipulations set forth herein.

Notice Requirements - To be protected by USERRA and to continue health coverage, an employee must generally provide the Employer with advance notice of his military service. Notice may be written or oral, or may be given by an appropriate officer of the military branch in which the employee will be serving. Notice will not be required to the extent that military necessity prevents the giving of notice or if the giving of notice is otherwise impossible or unreasonable under the relevant circumstances. If the employee's ability to give advance notice was impossible, unreasonable or precluded by military necessity, then the employee may elect to continue coverage at the first available moment and the employee will be retroactively reinstated in the Plan to the last day of active employment before leaving for active military service. The employee will be responsible for payment of all back premiums from date of termination of Plan coverage. No administrative or reinstatement charges will be imposed.

If the employee provides the Employer with advance notice of his military service but fails to elect continuation of coverage under USERRA, the Plan Administrator will continue coverage for the first thirty (30) days after employee's departure from employment due to active military service. The Plan Administrator will terminate coverage if employee's notice to elect coverage is not received by the end of the 30-day period. If the employee subsequently elects to continue coverage while on active military service and within the time set forth in the subsection entitled "Maximum Period of Coverage" below, then the employee will be retroactively reinstated in the Plan as of the last day of active employment before leaving for active military service. The employee will be responsible for payment of all back premium charges from the date Plan coverage terminated.

FEDERAL LAWS AFFECTING HEALTH & WELFARE BENEFITS

Cost of USERRA Continuation Coverage - The employee must pay the cost of coverage (herein "premium"). The premium may not exceed 102% of the actual cost of coverage, and may not exceed the active employee cost share if the military leave is less than 31 days. If the employee fails to make timely payment within the same time period applicable to those enrollees of the plan continuing coverage under COBRA, the Plan Administrator will terminate the employee's coverage at the end of the month for which the last premium payment was made. If the employee applies for reinstatement to the Plan while still on active military service and otherwise meets the requirements of the Plan and of USERRA, the Plan Administrator will reinstate the employee to Plan coverage retroactive to the last day premium was paid. The employee will be responsible for payment of all back premium charges owed.

Maximum Period of Coverage - The maximum period of USERRA continuation coverage is the lesser of 24 months or the duration of employee's active military service.

Reinstatement of Coverage Following Active Duty - Regardless of whether an employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the employee returns to active employment if the employee was released under honorable conditions.

An employee returning from military leave must notify their employer of their intent to return to work. Notification (application for reemployment) must be made:

within 14 days after active military service ceases for military leave of 31-180 days; or

within 90 days of completion of military service for military leave of more than 180 days.

No reemployment application is required if the military leave is less than 31 days. In that case, generally the employee need only report for work on the next regularly scheduled workday after a reasonable period for travel and rest. Uniformed Service members who are unable to report back to work because they are in the hospital or recovering from an injury or illness suffered during active duty have up to two (2) years to apply for reemployment.

When coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the employee had not taken military leave and coverage had been continuous. No waiting period or preexisting condition exclusion can be imposed on a returning employee or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

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STATEMENT OF ERISA RIGHTS

Plan participants are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that a Plan participant shall be entitled to:

Receive Information About His/Her Plan and Benefits, if applicable (e.g., does not apply to plans with fewer than 100 participants at the beginning of a plan year). This includes the right to:

examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;

obtain, upon written request to the Plan Administrator, copies of documents governing the operation of a Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Where permitted by law, these documents may be provided electronically; and

receive a summary of a Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage. This includes:

the right to continue health care coverage for himself/herself, spouse or dependents if there is a loss of coverage under a Plan as a result of a Qualifying Event. The employee or his/her dependents may have to pay for such coverage. See the **COBRA Continuation Coverage** section for additional details about these rights. Federal COBRA applies only to employers with 20 or more employees; and

reduction or elimination of exclusionary periods of coverage for preexisting conditions under a Plan benefit, if he/she has creditable coverage from another plan. An individual should be provided a certificate of creditable coverage, free of charge, from his/her group health plan or health insurance issuer when he/she loses coverage under a plan, when he/she becomes entitled to elect COBRA continuation coverage, when his/her COBRA continuation coverage ceases, if he/she requests it before losing coverage or if he/she requests it up to 24 months after losing coverage. Without evidence of creditable coverage, he/she may be subject to a preexisting condition exclusion of up to 12 months (18 months for late enrollees) after his/her enrollment date in the Plan. Plan participants should refer to specific provisions in applicable group health benefit documents to determine if preexisting condition restrictions apply.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of a Plan (the fiduciaries). Fiduciaries have a duty to operate a Plan prudently and in the interest of Plan participants and beneficiaries. No one, including the employer, may fire a Plan participant or discriminate against him/her to prevent him/her from obtaining a welfare benefit or exercising rights under ERISA.

Enforce His/Her Rights

If an individual's claim for a welfare benefit is denied in whole or in part, he/she must receive a written explanation of the reason for the denial. He/she has the right to have the Plan Administrator review and reconsider his/her claim.

Under ERISA there are steps a Plan participant can take to enforce the above rights. For instance, if he/she requests materials from a Plan and does not receive them within 30 days, he/she may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay him/her up to \$110 a day until he/she receives the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If he/she has a claim for benefits which is denied or ignored, in whole or in part, he/she may file suit in a state or Federal court once he/she has completed the Plan's administrative appeal procedures. In addition, if he/she disagrees with the Plan decision or lack thereof, concerning the qualified status of a medical child support order (QMCSO), he/she may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if he/she is discriminated against for asserting his/her rights, he/she may seek assistance from the U.S. Department of Labor, or he/she may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If he/she is successful, the court may order the person he/she has sued to pay these costs and fees. If he/she loses, the court may order him/her to pay these costs and fees, for example, if it finds his/her claim is frivolous.

Assistance With His/Her Questions

If a Plan participant has any questions about a Plan, he/she should contact the Plan Administrator. If he/she has any questions about this statement or about his/her rights under ERISA, or if he/she needs assistance in obtaining documents from the Plan Administrator, he/she should contact: (1) the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor as listed in his/her telephone directory, or (2) the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. A Plan participant may also obtain certain publications about his/her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

COBRA CONTINUATION COVERAGE

To comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan may include a continuation of coverage option. COBRA applies to employers with twenty (20) or more employees on a typical business day in the preceding Calendar Year. COBRA is available to certain Plan participants whose health care coverage(s) under the Plan would otherwise terminate. Plan participants should review the applicable Benefit Document or contact their COBRA Administrator for governing details. The following is only a summary of the major features of the law.

NOTE: Life insurance, accidental death and dismemberment benefits and short-term or long-term disability benefits (if part of the employer's Plan) are not eligible for continuation under COBRA.

Definitions - When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary - An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered employee, or the covered dependent spouse or child of a covered employee.

Any child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverage, the same coverage that a dependent child of an active employee would receive. The employee's Qualifying Event date and resultant continuation coverage period also apply to the child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he/she was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

Exception: An individual is not a Qualified Beneficiary if the individual's status as a covered employee is attributable to a period in which he/she was a nonresident alien who received no earned income from the employer that constituted income from sources within the United States. If such an employee is not a Qualified Beneficiary, then a spouse or dependent child of the employee is not a Qualified Beneficiary by virtue of the relationship to the employee.

NOTE: Under federal law, domestic partners (and their children) do not have independent COBRA election rights. However, some group health providers (e.g., insurance carriers) will extend COBRA-like election rights to such individuals as if they were COBRA qualified beneficiaries.

Qualifying Event - Any of the following events which would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

voluntary or involuntary termination of employee's employment for any reason other than employee's gross misconduct;

reduction in an employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the employee fails to return to work at the expiration of the leave, even if the employee fails to pay his/her portion of the cost of Plan coverage during the FMLA leave;

for an employee's spouse or child, employee's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the employee has been notified that his/her Medicare coverage is in effect;

for an employee's spouse or child, the divorce or legal separation of the employee and spouse;

for an employee's spouse or child, the death of the covered employee;

for an employee's child, the child's loss of dependent status (e.g., a child reaching the maximum age limit).

NonCOBRA Beneficiary - An individual who is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

COBRA CONTINUATION COVERAGE

Notification - If the Employer is the Plan Administrator and if the Qualifying Event is employee's termination/reduction in hours, death, or Medicare entitlement, then the Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights, or the unavailability of COBRA rights, within 44 days of the event. If the Employer is not the Plan Administrator, then the Employer's notification to the Plan Administrator must occur within 30 days of the Qualifying Event and the Plan Administrator must provide Qualified Beneficiaries with their COBRA rights notice within 14 days thereafter. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

If COBRA continuation coverage terminates early (e.g., the Employer ceases to provide any group health coverage, a Qualified Beneficiary fails to pay a required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election, etc.), the Plan Administrator must provide the Qualified Beneficiary(ies) with notification of such early termination. Notice must include the reason for early termination, the date of termination and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred which permits him to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is a dependent child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the employee from his/her spouse. A Qualified Beneficiary is also responsible for other notifications. See the "COBRA Notice Requirements for Plan Participants" in the **IMPORTANT NOTICES** section (or see the employer's "COBRA General Notice" or "Initial Notice") for further details and time limits imposed on such notifications. Upon receipt of a notice, the Plan Administrator must notify the Qualified Beneficiary(ies) of their continuation rights within 14 days.

Election and Election Period - COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary. Failure to make a COBRA election within the 60-day period will result in the inability to elect COBRA continuation coverage. See NOTE.

If the COBRA election of a covered employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the employer or Plan Administrator.

Where open enrollment rights allow NonCOBRA Beneficiaries to choose among any available coverage options, such rights are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he/she does not have special enrollment rights, even though active employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

NOTE: See the "Effect of the Trade Act" provision for information regarding a second 60-day election period allowance.

COBRA CONTINUATION COVERAGE

Effective Date of Coverage - COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his/her waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

Level of Benefits - COBRA continuation coverage will be equivalent to coverage provided to similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated NonCOBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to his/her deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

Cost of Continuation Coverage - The cost of COBRA continuation coverage is fixed in advance for a 12-month determination period and will not exceed 102% of the Plan's full cost of coverage during the period for similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the employer for NonCOBRA Beneficiaries. Qualified Beneficiaries will be charged 150% of the full cost for the 11-month disability extension period if the disabled person is among those extending coverage.

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. If payment is not made within such time period, the COBRA election is null and void. The initial premium payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment.

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase during the Plan's 12-month determination period if:

- the cost previously charged was less than the maximum permitted by law;

- the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law which is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or

- the Qualified Beneficiary changes his/her coverage option(s) which results in a different coverage cost.

Timely payments which are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least 30 days) to make full payment. A payment will be considered an "insignificant shortfall" if it is not greater than \$50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTES: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically-indigent or due to a certain disability. The employer's benefits department should be contacted for additional information.

COBRA CONTINUATION COVERAGE

Maximum Coverage Periods - The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

if the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the loss of coverage due to the Qualifying Event. With a disability extension (see "Disability Extension" information below), the 18 months is extended to 29 months;

if the Qualifying Event occurs to a dependent due to employee's enrollment in the Medicare program before the employee himself/herself experiences a Qualifying Event, the maximum coverage period for the dependent is 36 months from the date the employee is enrolled in Medicare;

for any other Qualifying Event, the maximum coverage period ends 36 months after the date of loss of coverage due to the Qualifying Event.

If a Qualifying Event occurs which provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first Qualifying Event.

COBRA entitlement runs concurrently with continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) - USERRA does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

Disability Extension - An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to be disabled during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date which falls within the allowable periods described. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his/her family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension himself/herself.

Termination of Continuation Coverage - Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the loss of coverage due to the Qualifying Event and ending on the earliest of the following dates:

the last day of the applicable maximum coverage period - see "Maximum Coverage Periods" above;

the date on which the employer ceases to provide any group health plan to any employee;

the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any pre-existing condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary;

the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his/her Medicare coverage is in effect;

in the case of a Qualified Beneficiary entitled to a disability extension, the later of:

29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

COBRA CONTINUATION COVERAGE

the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;

the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated NonCOBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

Effect of the Trade Act - In response to Public Law 107-210, referred to as the Trade Act of 2002 ("TAA"), the Plan is deemed to be "Qualified Health Insurance" pursuant to TAA, the Plan provides COBRA continuation of coverage in the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, as amended.

Eligible Individuals - The Plan Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation ("PBGC"), pursuant to TAA as of or after November 4, 2002. The Plan Administrator shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement, federal income tax filings, etc. The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

Temporary Extension of COBRA Election Period

In the case of an otherwise COBRA Qualified Beneficiary who is a Nonelecting TAA-Eligible Individual (see "Definitions", below), such individual may elect COBRA continuation of coverage during the TAA-Related Election Period, but only if such election is made not later than 6 months after the date of the TAA-Related Loss of Coverage.

Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period, and shall not include any period prior to the such individual's TAA-Related Election Period.

Definitions:

Nonelecting TAA-Eligible Individual - A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA continuation coverage during the TAA-Related Election Period.

TAA-Eligible Individual – An eligible TAA recipient and an eligible alternative TAA recipient.

TAA-Related Election Period – with respect to a TAA-related loss of coverage, the 60-day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual.

TAA-Related Loss of Coverage – means, with respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period, and shall not include any period prior to the such individual's TAA-Related Election Period.

HIPAA Creditable Coverage Credit

With respect to any TAA-Eligible Individual who elects COBRA continuation of coverage as a Nonelecting TAA Individual, the period beginning on the date the TAA-Related Loss of Coverage, and ending on the first day of the TAA-Related Election Period shall be disregarded for purposes of determining the 63-day break-in-coverage period pursuant to HIPAA rules regarding determination of prior creditable coverage for application to the Plan's pre-existing condition exclusion provision.

COBRA CONTINUATION COVERAGE

Applicable Cost of Coverage Payments

Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA-Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in IRS regulations 54.4980B-8, A-5(d), the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.

Conversion - If the Plan Sponsor offers a conversion privilege to NonCOBRA Beneficiaries and in conjunction with the health benefits of the Plan, then a Qualified Beneficiary has the right to exercise the conversion option when he/she reaches the end of his/her COBRA continuation coverage.

The option to enroll in the conversion health plan must be given within 180 days before COBRA coverage ends. The premium for a conversion policy may be more expensive than the cost of COBRA coverage or the cost of Plan coverage. Also, the conversion policy may provide a lower level of coverage.

The conversion option is not available if the Qualified Beneficiary terminates COBRA coverage before reaching the end of the maximum period of COBRA coverage.

FEDERAL CLAIMS GUIDELINES

The following information provides a brief overview of the federal minimum requirements for claims handling procedures. The actual claims procedures for a given benefit should be included in the respective "Benefit Document" and may be less restrictive as to the claimant's responsibilities. See the appropriate "Benefit Document" for information.

The following claims procedures are intended to comply with the United States Department of Labor ("DOL") regulation, 29 CFR § 2560.503-1, and the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Where any provision is in conflict with the DOL's claims procedure regulations, ERISA, or any other applicable law, such law shall control.

Further, if the Plan is the "named insured" with an insurance company, nothing herein shall be construed to supersede any provision of state law that regulates insurance, except to the extent that such law prevents application of a requirement of DOL regulation 29 CFR § 2560.503-1.

A "CLAIM" DEFINED

The claims guidelines outlined herein affect the following types of group benefits:

Health benefits (i.e., medical benefits and including dental and vision benefits when part of a medical benefit plan)

Health FSA provided through a flexible spending or "cafeteria" plan under Section 125 of the Internal Revenue Code

Disability benefits (i.e., wage replacement benefits)

The guidelines differ in some regards from one benefit to another and those differences are outlined below.

The Plan Administrator, at its discretion, may contract with other entities to handle claims communications and benefit determinations for the Plan. Such other entities may include insurance companies, third party claims payers, managed care organizations, or pharmacy benefit managers.

A Health Claim

A group health claim is a request for benefits which is made, in accordance with the Plan's procedures, by a claimant or his/her authorized representative. A claim must be received by the person or organizational unit customarily responsible for handling benefit matters on behalf of the Plan so that the claim review and benefit determination process can begin. A claim must name the Plan, a specific claimant, a specific health condition or symptom or diagnostic code, and a specific treatment, service or supply (or procedure/revenue code) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services are received, and provider name, address, phone number and tax identification number.

There are two types of group health claims: (1) Pre-Service Claims, and (2) Post-Service Claims:

- 1) **A Pre-Service Claim** is a written or oral claim where benefits are subject, in whole or in part, to prior approval of the proposed care (e.g., a utilization review requirement). See the applicable Benefit Document(s) in the **PLAN BENEFITS** for pre-approval programs and requirements. A Pre-Service Claim should be made to the organization identified in the Benefit Document or as may be shown on the employee's coverage identification card.

Important: A benefit determination for a Pre-Service Claim shall only be for the purposes of assessing the medical necessity and appropriateness of care and delivery setting. A benefit determination for a Pre-Service Claim is not a guarantee of benefits from the Plan. Plan benefit payments are subject to review upon submission of a claim to the Plan after medical services have been received, and are subject to all related Plan provisions, including exclusions and limitations.

- 2) **A Post-Service Claim** is a written request for benefit determination after a service has been rendered and expense has been incurred. A Post-Service Claim must be submitted within the reasonable claims-filing time requirements as included in the Benefit Document. A Post-Service Claim should be submitted to the claims office identified in the appropriate Benefit Document or as may be shown on the employee's coverage identification card.

A Health FSA Claim (an IRC Section 125 or “cafeteria” benefit)

A Health FSA claim is a written request for reimbursement from an employee’s health care “reserve account.” The employee will be required to furnish such documents, evidence, data or information in support of his/her claim (bills, cancelled checks, or other proof of expense and proof of payment, etc.) as the Plan Sponsor or claims office considers necessary. Also, the employee must provide a written statement that the expense has not been reimbursed and is not reimbursable under any other health plan and will not be claimed as a federal income tax deduction.

See the “Post Service Claim Activity” time limits and allowances in the Health Claims Guidelines chart, below. That portion of the chart applies to claims for Health FSA reimbursement.

A Disability Claim

A disability claim is a written request for wage replacement benefits that is made by an employee or his/her authorized representative. It must name the employee, the date the disability started, the cause of the disability, and the seriousness of the disability.

A disability claim should be submitted to the claims office identified in the appropriate Benefit Document.

CHART(S) OF CLAIMS TIME LIMITS AND ALLOWANCES

The chart(s) below reflect the time limits and allowances which apply to the Plan and a claimant with respect to claims filings, administration and benefit determinations (i.e., how quickly the Plan must respond to claims notices, filings and claims appeals and how much time is allowed for claimants to respond, etc.).

Important: The stated claims procedures herein address the periods within which claims determinations must be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval as governed by ERISA. Further, with regard to preemption of state law, nothing herein shall be construed to supersede any provision of state law that regulates insurance, except to the extent that such law prevents the application of a requirement of U.S. Department of Labor Regulation 29 CFR § 2560.503-1.

HEALTH CLAIM GUIDELINES	
“PRE-SERVICE” CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Urgent Claim - defined below	
Claimant Makes Initial <u>Incomplete</u> Claim Request	Within no more than 24 hours (and as soon as possible taking into account the medical exigencies), Plan notifies claimant of material needed to complete the claim request. Notification may be oral unless claimant requests a written notice. Claimant will have at least 48 hours to provide the required information to complete the claim.
Plan Receives <u>Completing</u> Information	Plan notifies claimant, in writing or electronically, of its benefit determination as soon as possible and not later than 48 hours after the earlier of: (1) receipt of the completing information, or (2) the period of time claimant was allowed to provide the completing information.
Claimant Makes Initial <u>Complete</u> Claim Request	Within no more than 72 hours (and as soon as possible taking into account the medical exigencies), Plan responds with written or electronic benefit determination.
Claimant Appeals	See "Appeal Procedures" subsection. An appeal for an urgent claim may be made orally or in writing.
Plan Responds to Appeal	Within no more than 72 hours (and as soon as possible taking into account the medical exigencies), after receipt of claimant's appeal.

An "urgent claim" is an oral or written request for benefit determination where the decision would result in either of the following if decided within the time frames for non-urgent claims: (1) serious jeopardy to the claimant's life or health, or the ability to regain maximum function, or (2) in the judgment of a physician knowledgeable about the claimant's condition, severe pain that could not be adequately managed without the care or treatment being claimed.

Where the "Time Limit or Allowance" stated above reflects "or sooner if possible", this phrase means that an earlier response may be required, taking into account the medical exigencies.

Concurrent Care Claim - defined below

Plan Makes an Adverse Claim Decision

Plan notifies claimant of intent to reduce or deny benefits before any reduction or termination of benefits is made and provides enough time to allow the claimant to appeal and obtain a determination on review before the benefit is reduced or terminated. Any decision with the potential of causing disruption to ongoing care which is medically necessary, is subject to the urgent claim rules.

Claimant Requests Extension for Urgent Care

Plan notifies claimant of its benefit determination within not more than 24 hours after receipt of the request (and as soon as possible taking into account the medical exigencies), provided such request is made at least 24 hours prior to the expiration of the previously-approved period of time or treatment. Otherwise, the Plan's notification must be made in accordance with the time allowances for appeal of an urgent, pre-service or post-service claim, as appropriate.

A "concurrent care claim" is a claimant's request to extend a previously-approved and ongoing course of treatment (e.g., kidney dialysis) beyond the approved period of time or number of treatments. An adverse claim decision for concurrent care does not include a benefit reduction or denial due to Plan amendment or termination.

Non-Urgent Claim

Claimant Makes Initial Incomplete Claim Request

Within 5 days of receipt of the incomplete claim request, Plan notifies claimant, orally or in writing, of material needed to complete the claim request. Claimant may request a written notification.

Plan Receives Completing Information

Plan responds with written or electronic benefit determination within 15 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.

Claimant Makes Initial Complete Claim Request

Within 15 days, Plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to claimant - see definition of "full notice" below.

Claimant Appeals

See "Appeal Procedures" subsection.

Plan Responds to Appeal

Within 30 days after receipt of appeal (or where Plan provides for 2 mandatory levels of appeal, within 15 days for each appeal).

"Full notice" means that notice is provided to the claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to claimant must occur prior to the expiration of the initial 15-day period.

"POST-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Claimant Makes Initial <u>Incomplete</u> Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises claimant of material needed to complete the claim request. The Plan may extend this period for up to 15 days with full notice to the claimant - see definition of "full notice" below.
Plan Receives Completing Information	Plan approves or denies claim within 30 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Makes Initial <u>Complete</u> Claim Request	Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to claimant - see definition of "full notice" below.
Claimant Appeals	See "Appeals Procedures" subsection.
Plan Responds to Appeal	Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels).
<p>"Full notice" means that notice is provided to the claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period.</p>	

DISABILITY CLAIM GUIDELINES	
CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Notice of Claim	Written notice of a claim for disability benefits must be submitted to the Plan's claims office within a reasonable period (<i>typically 30 days</i>), if possible. If that is not possible, the claims office must be notified as soon as reasonably possible.
Claim Forms are Provided	Upon receipt of notice of a claim, the claims office will provide the employee with claim forms. If the forms are not received within a reasonable period (<i>typically 15 days</i>), the employee may submit his/her proof of claim to the claims office without the use of forms.
Proof of Claim	Proof of claim must be provided to the claims office as required by the Benefit Document (typically no later than 90 days unless not reasonably possible and then up to one year is usually allowed).
Benefit Determination	Within 45 days after receiving complete proof of claim, the claims office responds with written or electronic benefit determination. 30 additional days may be allowed. A second 30-day extension may also be allowed. See NOTE below.
<p>NOTE: An initial 30-day extension will be allowed with full notice to the employee. A second 30-day extension is allowed if the claims office determines that a decision cannot be rendered within the initial 30-day extension. Notice to the employee must occur prior to the expiration of the initial 30-day extension period and must include the date by which the Plan expects to render a decision.</p>	
Proof of Continued Disability	Proof of continued disability and regular attendance of a physician must be given to the claims office within the time period required by the Benefit Document (<i>typically 30 days</i>) upon any request of such proof on the part of the claims office.

Employee's Right of Appeal	Employee is allowed at least 180 days to file an appeal following receipt of notice of an adverse benefit determination (i.e., a full or partial denial of benefits). See "Appeal Procedures" subsection.
Employee Files an Appeal	The Plan Administrator must respond with written or electronic benefit determination within 45 days after receipt of an appeal. 45 additional days may be allowed - see NOTE.
NOTE: A 45-day extension will be allowed with full notice to the employee.	

ADMINISTRATIVE INFORMATION

Authorized Representative May Act for Claimant

Any claim-related actions which can be done by a claimant can also be done by an authorized representative acting on the claimant's behalf. The claimant may be required to provide reasonable proof of such authorization.

For an urgent group health claim, a health care professional, with knowledge of a claimant's medical condition, may act as the authorized representative of the claimant. "Health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Written or Electronic Notices

The Plan shall provide a claimant with written or electronic notification of any benefit reduction or denial. Written or electronic notice of an approved benefit must be provided only for a group health Pre-Service benefit determination.

CLAIMS DENIALS

If a claim is wholly or partially denied, the claimant will be given written or electronic notification of such denial within the time frames required by law - see "Claims Time Limits and Allowances." The notice will include the following and will be provided in a manner intended to be understood by the claimant:

- the specific reason(s) for the decision to reduce or deny benefits;
- specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols which were relied upon in making the decision;
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to the claimant's claim for benefits;
- a description of any additional information needed to change the decision and an explanation of why it is needed; and
- a description of the Plan's procedures and time limits for appealed claims, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA.

APPEAL PROCEDURES

Non-grandfathered Group Health Plan

A non-grandfathered group health plan must have claims and appeals procedures that satisfy the requirements of the ERISA claims regulations. This requirement also applies to governmental plans and church plans. In addition and effective on Plan Year anniversaries after September 23, 2010, the claims appeals procedures of a non-grandfathered group health plan, regardless of ERISA status, must satisfy the additional requirements pursuant to Health Care Reform. See the **Overview of Health Care Reform Mandates** section for more information.

Filing an Appeal

Within 180 days of receiving notice of a claim reduction or denial, a claimant may appeal his/her claim, in writing, to a new decision-maker and he/she may submit new information (comments, documents, records, etc.) in support of his/her appeal.

In response to his/her appeal, the claimant is entitled to a full and fair review of the claim and a new decision. A "full and fair review" takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

At such time as the claimant appeals a denied claim, he/she will be provided, upon request and free of charge, with access to and copies of all documents, records and other information relevant to his/her claim for benefits.

Decision on Appeal

A decision with regard to the claim appeal will be made within the allowed time frame - see "Claims Time Limits and Allowances."

The decision on appeal will be in writing or by electronic notification. If the decision is to continue to reduce or deny benefits, the notification will be provided in a manner calculated to be understood by the claimant and will include:

the specific reason(s) for the decision;

reference to the pertinent Plan provisions on which the decision is based;

a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;

identification of and access to any guidelines, rules, protocols which were relied upon in making the decision; and

a statement describing any voluntary appeal procedures offered by the Plan, the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under ERISA section 502(a).

A Plan participant and the Plan may have other voluntary alternative dispute resolutions options, such as mediation. One way to find out what may be available is to contact the Local U.S. Department of Labor Office and the State insurance regulatory agency.

In accordance with federal law, the Plan cannot require more than two (2) levels of mandatory appeal. If more than one (1) level of mandatory appeal is required, both must be completed within the time frame applicable to one (1) level.

Voluntary Additional Levels of Appeal

Subject to the Plan's established procedures, up to two (2) voluntary additional levels of appeal (including arbitration or any other form of dispute resolution) are permitted, but only after exhaustion of the Plan's mandatory appeal procedure.

ADOPTION OF WRAP SPD AS STATEMENT OF PLAN

By authorized signature below, the Plan Sponsor adopts the **Wraparound Summary Plan Description of Employee Benefits of Roger Williams University** together with all controlling contracts or "Benefit Documents" that are incorporated by reference, as the statement or Plan Document of the **Roger Williams University Welfare Plan – Plan # 501**.

RIGHT TO AMEND, MODIFY OR TERMINATE THE PLAN OR ANY BENEFITS OF THE PLAN

Since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor reserves the right, without the consent of any participant or beneficiary, to:

make any modifications or amendments to the Plan as may be necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code or ERISA; and

reduce or terminate any retiree benefits under the Plan; and

terminate, suspend, withdraw, amend or modify the Plan, in whole or in part and at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an employee or Plan participant of a right to benefits to which he/she has become entitled.

NOTE: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's board of directors, or by written amendment that is signed by at least one Fiduciary of the Plan. Employees will be provided with notice of the change within the time allowed by federal law.

ADOPTION OF WRAP SPD AS THE "PLAN DOCUMENT"

IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed on January 1, 2014

Roger Williams University (Plan Sponsor)

By:

Name:

Title:

Witness:

Name:

Title:



Jerome F. Williams

Executive Vice President for Finance and Administration



Mirlen A. Mal

Assistant Vice President for Human Resources
